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# *INDIANA* **Epidemiology** *NEWSLETTER*

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Epidemiology Resource Center  
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## **Fireworks - Related Injuries**

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Legislation passed this year by the Indiana General Assembly (HEA 1131) requires physicians, hospitals, and outpatient surgery centers to report all injuries resulting from fireworks or pyrotechnics to the Indiana State Department of Health. This report presents data compiled from reports received from May 13 – July 19, 2003.

### **Highlights**

- As of July 19th, there were 261 unduplicated cases reported to ISDH.
- Fifty-three percent of all fireworks-related injuries reported involve children and adolescents, who represent a fourth of the population in Indiana.
- Three fourths of cases reported sustained burn injuries, with burns of the hands being the most common type of injury.
- About 20% of all injuries reported involved the eyes, with 82% of those with eye injuries not using any method of eye protection.
- Eleven percent of injured persons required either hospital admission or specialized care for burns or eye injuries.
- Sparklers, rockets and firecrackers were associated with 63% of all injuries reported.
- Fireworks use on private property accounts for more than 80% of the injuries reported.

### **Table of Contents:**

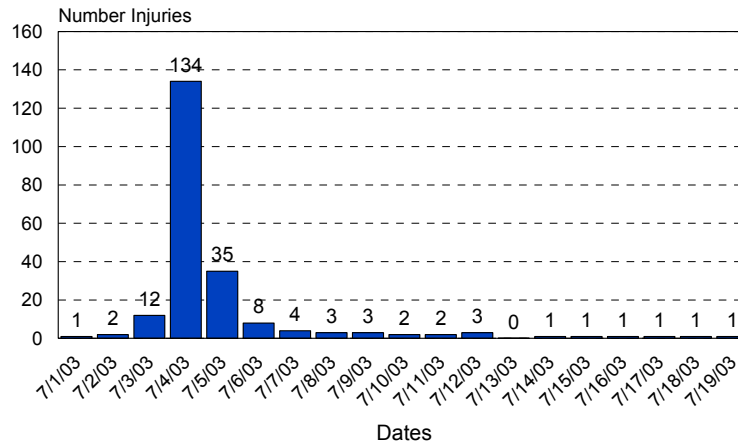
<b>Article</b>	<b>Page No.</b>
Fireworks - Related Injuries . . . . .	1
Progress on Statewide Immunization Registry . . . . .	5
Indiana's NIS Rate on the Rise . . . . .	6
USDA Free Fruit and Vegetable Pilot Program . . . . .	10
Training Room . . . . .	14
Wonderful Wide Web Sites . . . . .	15
HIV Disease Summary . . . . .	15
Reported Cases of selected . . . . .	16
notifiable diseases	

## Fireworks-Related Injuries

- Seventy-three percent (190) of the reported injuries involved males and 27% (71) involved females.
- Eighty-four percent (219) of the injuries occurred among whites; Black/African Americans accounted for 10% (25) of all injuries.
- The median age of those injured was 18 years (average=20 years; range=6 weeks to 74 years).
- The first case was reported on May 13, 2003 with a total of three cases reported for the month of May. Thirty-one cases were reported in June and 216 cases were reported in July.
- Fifty-two percent (134) of the injuries occurred on July 4th and 76% (189) of all injuries occurred between July 3 and 6.

Figure 1.

### Indiana Fireworks - Related Injuries July 1-19, 2003



The types of fireworks most frequently resulting in injury (63% in total) were sparklers, rockets, and firecrackers (Table 1). Injuries from many other types of fireworks were also reported, including ¼ stick of dynamite, smoke bombs, and spewed strobe lights. Although 27% (70) of the reports noted that the injury resulted from mishandling fireworks, 36% (95) reported that the injury resulted from fireworks malfunction or an errant path of a rocket.



Seventy-six percent (198) of the cases experienced injury from burns. Of these, seventy% (139) received second-degree burns and 7% (13) had third degree burns. Other types of injuries included contusions/lacerations/abrasions (48 cases), penetrating foreign body/missiles (16 cases), puncture wounds (6 cases) and sprains/fractures (2 cases). One-half of injuries involved the hands or eyes, although injuries to many parts of the body were reported (Table 2).

Among the 92% (240) of cases who reported the location of the activity that resulted in injuries, 59% of injuries (142) occurred at the injured person's private home, yard, or property. A friend, neighbor, or relative's home or property was involved in 24% (57); public property was noted for 10% (24).



Although most reports (226) did not provide information on alcohol consumption, 13% (35) stated that alcohol was imbibed before to the injury and 26 of these noted alcohol use within three hours of the injury. Three adolescents reported using alcohol. An additional 10% (25) of the injury reports stated that other people at the scene used alcohol.

Fourteen percent (37) of all people injured were bystanders. Among those injured who were less than 18 years of age, 60% (83) of the injuries happened while in the presence of an adult.

**Table 1: Frequency of Type of Fireworks Involved in Injury, All Injuries.**

Type of Fireworks / Pyrotechnics	Frequency	Percent
Sparkler	61	23.4%
Rockets (i.e., bottle rockets)	56	21.5%
Firecrackers	48	18.4%
Aerial Devices	21	8.0%
Pyrotechnics*	15	5.7%
Twister / “Jumping Jacks”	8	3.1%
Lightning Gunpowder	3	1.1%
Homemade, altered devices	2	0.8%
Unspecified / Unknown / Other	47	18.0%
<b>Total</b>	<b>261</b>	<b>100%</b>

\*Upon review of the reported injuries, the Office of the State Fire Marshal determined that only 1 of the 15 reported pyrotechnic related injuries actually resulted from a true indoor pyrotechnic display. The 14 other reported pyrotechnic related injuries resulted from outdoor fireworks displays.

**Table 2. Frequency of Body Part Injured, All Injuries.**

Body Part Involved**	Frequency**	Percent of Injured Persons**	Percent of All Injuries**
Hand	114	43.7%	34.2%
Eye	57	21.8%	17.1%
Leg	46	17.6%	13.8%
Face/Ears/Head	40	15.3%	12.0%
Arm	39	14.9%	11.7%
Trunk	30	11.5%	9.0%
Other	7	2.7%	2.1%
<b>Total</b>	<b>333</b>	<b>127.6%</b>	<b>100%</b>

\*\*Not mutually exclusive, some cases received injuries to multiple body parts.

## Children: Six Weeks Through Eleven Years of Age

There were 78 (55 male and 23 female) injuries reported in children. The types of fireworks mainly resulting in injury included sparklers (32 cases), rockets (13 cases) and firecrackers (11 cases). Burns were sustained by 85% (66) of the cases in this age group. The majority of these injuries (72% or 56) happened in the presence of an adult. Twelve of the injured children were bystanders. The only child admitted to a hospital was a one-year old bystander who sustained first and second degree burns.

## **Adolescents: Twelve Through Eighteen Years of Age**

Among adolescents, there were 60 fireworks-related injuries, involving 46 males and 14 females. Seventy-three percent of the cases experienced burn injuries. One person sustained probable loss of vision in the left eye. Two cases were admitted to hospitals. Four cases were transferred to or re-evaluated at more specialized healthcare sites (i.e., burn centers, eye centers). Twenty-seven injuries (45%) occurred while in the presence of an adult. Eight of the injured were bystanders.

## **Adults: Nineteen Years of Age and Older**

There were 123 injuries (47% of all cases) reported among those aged nineteen years and older. Seventy-two percent (88) of the adults experienced burn injuries. Hand injuries were reported 61 times. Of the 22 cases with eye injuries, sixteen were not wearing eye protection and two had eyeglasses or safety glasses (four unknowns). Six cases were admitted to hospitals. Eleven cases were transferred to or re-evaluated at more specialized healthcare sites (i.e., burn centers, eye centers). The use of alcohol was reported by 26% (32) of injured adults. Seventeen of the injured cases were bystanders.

## **Summary**

For the 261 cases of fireworks-related injury that comprise this report, three-fourths of all injuries reported occurred from July 3<sup>rd</sup>- 6<sup>th</sup>, including 52 (134)% of injuries that took place on Independence Day. While those injured ranged in age from 6 weeks to 74 years, children and adolescents comprised over one-half (53%) of the reported cases. According to the 2000 U.S. Census population estimates for Indiana, persons under 18 years of age represent only a fourth of the population. Adults were present 60% of the time for injuries reported in children and adolescents. Males were involved in almost three-fourths of all cases reported, which is a common finding for many traumatic injuries. The racial distribution of those injured was similar to that of the population of Indiana.

As expected, burns were the most frequent type of injury, involving 76% (198) of all reported cases. While the hands were the body part most commonly injured (34%), injuries to the eye (17%) were also quite frequent, with the great majority (82%) of those with eye injuries reporting no method of eye protection in use. Bystanders were injured in 14% (37) of reported cases. Hospital admission was needed for 3.4% of those injured, with an additional 7.7% requiring specialized care for either burn injuries or eye injuries. There were no deaths reported related to fireworks injuries during the time period of this report.

When the location of the activity using fireworks was identified, 83% (199) of cases reported occurred at private home, yard, or property (self-owned or friend, neighbor or relative). The type of fireworks involved in injuries varied somewhat by age, with sparklers causing the most injuries in young children, rockets, sparklers and firecrackers involved in adolescents, and a fairly equal distribution of these three types of fireworks also affecting injured adults.

Mishandling or malfunction of fireworks was the most frequent mechanism reported for fireworks-associated injury, accounting for about one-half of all those injured. Although alcohol use was not stated for 87% of the reported cases, alcohol use occurred at the scene of activities affecting injured persons of all age groups. One-quarter of the adults injured reported the use of alcohol.

For more information, contact Sandra Beck at [Sbeck@isdh.state.in.us](mailto:Sbeck@isdh.state.in.us) or Dr. Charlene Graves at [Cgraves@isdh.state.in.us](mailto:Cgraves@isdh.state.in.us).

## **Progress on Statewide Immunization Registry**

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Medical Director  
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Since January 2002, when the Indiana State Department of Health (ISDH) began the development of a statewide, Internet-based immunization registry, great progress has occurred in registry development. As of August 6, 2003, the Children and Hoosiers Immunization Registry Program (CHIRP) has immunization data on 1.8 million patients maintained in a secure database. This includes 13.5 million vaccinations received by both children and adults.

Through the work of a large number of ISDH Immunization Program staff and personnel from Scientific Technologies Corporation (STC), the vendor involved in this three-year project, CHIRP contains immunization data from all 94 local health departments in the state. There are now 1,476 registered users, including local health departments, other public facilities, and 38 private physicians. In addition, 123 school corporations have “View-Only” access to assist school nursing staff when performing the annual school audit that assesses immunization coverage of school-age children.

With the major goal accomplished of involving all local health departments in 2002, the focus for 2003 is targeted to outreach and enrollment of other public facilities (for example, community health centers) and physicians in private practice. Enrollment packets have been prepared, and outreach to these health care providers is planned to take place on a regional basis. Physicians who are already enrolled as Vaccines for Children (VFC) providers will initially be contacted, particularly those who are “high-volume” providers, based on the annual volume of immunizations administered. A recent change in state law allows for inclusion of patient immunization data in CHIRP without specific patient consent. Patients who choose not to participate can still “opt-out” by signing a form designed for that purpose. However, the advantages of CHIRP as a database to provide easy access to immunization records for actively enrolled health professionals is readily apparent to both providers and patients.

Medical and professional organizations, the state Medicaid program, WIC, and managed care organizations are all considered as community partners in this outreach effort to familiarize health care providers with the efficiency and ease of accessing immunization information through CHIRP. The Indiana Immunization Coalition has played an important role in supporting immunization registry development and will continue to be an advocate for CHIRP. Continued involvement with school systems will be enhanced and day care centers will become involved with CHIRP.

As noted in the article on Indiana’s current immunization coverage levels in this issue, one goal of the ISDH Immunization Program is to assure that at least 90% of two-year-old children are age-appropriately immunized. Continued development and implementation of CHIRP will ensure that a sustainable system has been established to monitor the percentage of children who are adequately immunized and assist in the attainment of this goal. More information about CHIRP can be obtained from the CHIRP website at <http://www.chirp.isdh.state.in.us> or by calling ISDH at (888) 227-4439.

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# Indiana's National Immunization Survey Rate on the Rise

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The National Immunization Survey (NIS) is an ongoing survey that provides estimates of vaccination coverage among children 19-35 months of age. The data are based on the most recent 12 months for each of the 50 states and 28 selected urban areas. The NIS was established to provide a consistent data set for analyzing vaccination levels among young children in the US and disseminating this information to interested public health partners. It also helps track progress towards Healthy People 2010 Goals. They are defined as follows:

- Achieve and maintain 90% vaccination coverage levels for universally recommended vaccines among children. Individual antigen goals are 90% coverage for 4 doses of DTaP, 3 Hib, 1 MMR, 3 Polio, and 1 Varicella.
- Increase the proportion of young children who receive all vaccines that have been recommended for universal administration for at least five years. Eighty percent (80%) of children aged 19-35 months should receive all vaccines that have been recommended for universal administration for at least five years. At the time the goal was written, recommended vaccines included 4 DTaP, 3 Polio, 1 MMR, 3 Hib, and 3 Hepatitis B.



This report describes trends in Indiana vaccination coverage rates based on NIS findings from 1995-2002 and shows progress toward the Healthy People 2010 Goals.

## NIS Study Design

The NIS uses random digit dialing to identify households with children aged 19 to 35 months. The survey asks parents or guardians to provide the vaccine information, including dates, that appear on the child's "shot card" kept in the home. Permission is then requested to contact the child's vaccination providers. Providers are contacted by mail to verify each child's vaccinations.

The NIS uses a nationally representative sample and provides estimates of coverage that are weighted to represent the national population, as well as populations by region, state, and selected large metropolitan areas. The large sample size allows the Centers for Disease Control and Prevention (CDC) to stratify the data to examine vaccination rates among different groups such as income level, race, education level of mothers, and other factors.

Complete NIS data for the U.S. and all states (with breakdowns listed above) can be found at the National Immunization NIS survey website at <http://www.cdc.gov/nip/coverage/default.htm>.

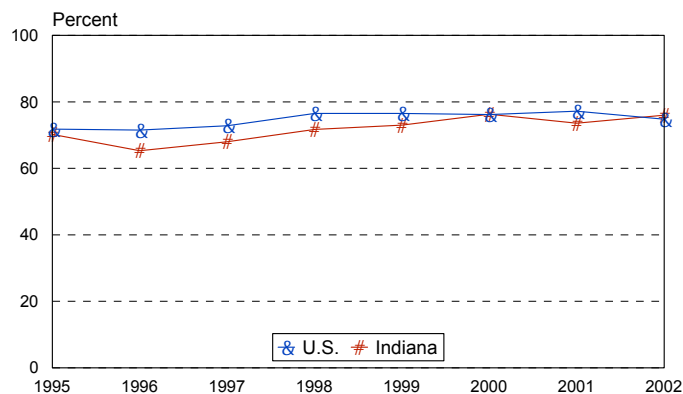
## Complete Series Data

The standard series of vaccinations considered up-to-date for two-year-old children from 1995-2001 was the 4:3:1:3 series (4 DTaP, 3 Polio, 1 MMR, and 3 Hib vaccinations). Three hepatitis B vaccinations were added to the standard set of vaccines, making 4:3:1:3:3 the complete series in 2002. For this article, data reported for 2002 will reflect this change in the standard series. Indiana's coverage rate was 76.3% in 2000 and 76.0% in 2002, the two highest levels achieved since the inception of the NIS for a complete year of data. The most current rate (2002) represents an increase of 10.7% complete (from 65.3%) since 1996, which is the lowest rate recorded in

Indiana since the NIS began collecting data. Indiana's complete series coverage rate consistently lagged behind the US rate during the 1990s by 2-6 percentage points. In 2000 and 2002, Indiana's rate equaled or exceeded the national rate (Figure 1). Indiana ranked 26<sup>th</sup> nationally (out of 50 states surveyed) in immunization coverage for the complete series in 2002, which is the highest ranking ever achieved. This was a marked increase from the state rankings when Indiana's rank ranged from 40-47 during the 1990s (Table 1).

**Figure 1.**

**Percent of Children 19-35 Months of Age  
Complete for Vaccine Series\***  
U.S. and Indiana, 1995-2002



\*Series complete from 1995-2001 = 4:3:1:3  
Series complete for 2002 = 4:3:1:3:3

**Table 1. Indiana's Ranking Among Other States – Complete Series**

Year	Ranking Among the Fifty States	Percent Complete
2002	26*	76.0
2001	38	73.6
2000	29	76.3
1999	47	73.0
1998	40	71.1
1997	46	68.0
1996	40	65.3
1995	43	70.2

\*Complete series = 4:3:1:3:3 for 2002 and 4:3:1:3 for all other years.

## Individual Antigen Data

In 2002, four individual antigens (Polio, MMR, Hib, Hep B) had coverage levels above the 90% objective. DTaP and varicella were below the 90% objective. Only four other states had a 90% rate or better for 4+ DTaPs and no state had achieved 90% for varicella coverage. Indiana's rate for 3+ pneumococcal conjugate (PCV) vaccines was 40.7%. PCV, being a newly licensed vaccine, had supply problems almost from the day it first became available in 2000. Only six states achieved a coverage rate over 50% for PCV, with the highest being 66.8% (Rhode Island). See Table 2 for individual antigen rates in Indiana for 2002.

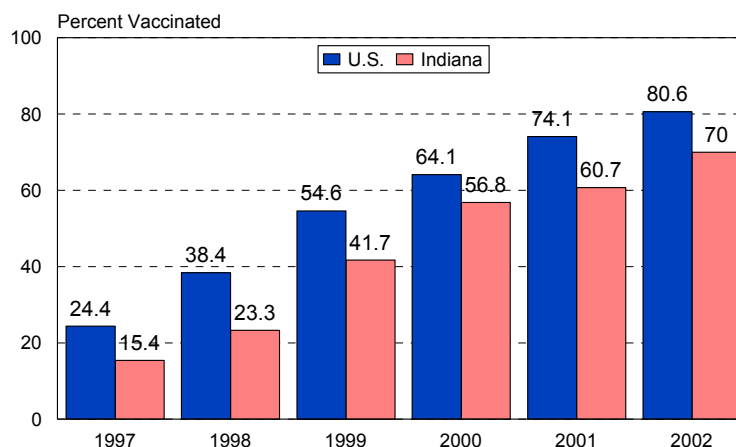
**Table 2. Individual Antigen Coverage Rates for Indiana, 2002**

3+HepB	3Hib	1MMR	3+Polio	4+DTaP	1Var	3+PCV
93.2	91.7	91.1%	90.5%	81.7%	70.0	40.7%

The rate for 4+ DTaP reported at 81.7% is a primary factor in keeping the series complete rates from reaching the stated objective. The rate for 3+ DTaPs was 13.5% higher than the rate for 4+DTaPs in 2002 (95.2% compared to 81.7%). A comparison of 3+DTaP and 4+DaP rates are shown in Figure 2. Aggressive reminding and recalling children for their fourth DTaP should have a positive effect on the complete series rate in Indiana.

**Figure 2.**

**Varicella Vaccine Coverage National Immunization Survey Results, Children 19-35 Months of Age**  
U.S. and Indiana, 1997-2002

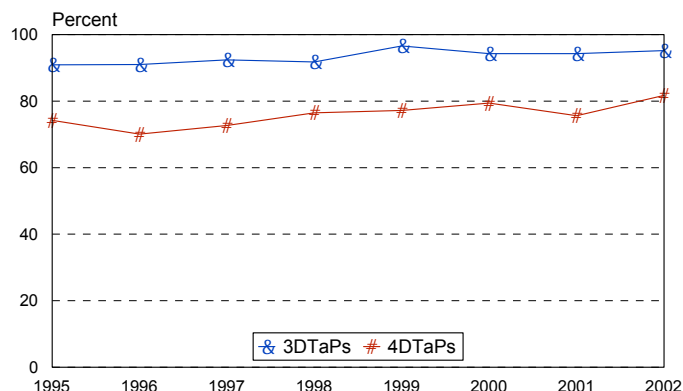


Indiana's coverage rate for varicella vaccine has lagged behind the national rate since the licensure of the vaccine in 1995 (Figure 3) and is currently at 70% as compared to 80.6% nationally. Indiana's rate has been 10-14% points below the national rate for varicella vaccine coverage since 1998. Increased coverage in Indiana may occur in the future as day care and school requirements for varicella vaccine are implemented. A one-dose requirement for new school enterers will take effect with the 2004-05 school year, and a one-dose requirement for day care center enrollees went into effect in January 2003.



**Figure 3.**

**Percent Comparison of Children 19-35  
Months of Age With 3 or 4 DTaPs**  
Indiana, 1995-2002



The findings described in the 2002 NIS report indicate that among U.S. and Indiana children 24 months of age, coverage with recommended vaccines remains near all-time highs. These high levels of immunization coverage have had a dramatic impact on the disease rate in the US and Indiana. There has not been a confirmed case of rubella or tetanus reported in Indiana since 1999. Only eight cases of measles (all imported) and 12 cases of mumps have occurred since 1999. No cases of any of those four diseases have occurred in 2003. Nationally in 2003, there have been no cases of diphtheria or polio, only 5 cases of tetanus and rubella, 35 cases of measles, 124 cases of mumps and 3,419 cases of pertussis. All childhood vaccine preventable diseases decreased dramatically in the 1990s except pertussis (see June issue of the Indiana Epidemiology Newsletter for discussion of pertussis disease).

Maintaining the gains in childhood vaccination rates attained during the 1990s and the first two years of the 21<sup>st</sup> century poses a constant challenge for public health. Since each annual birth cohort in the U.S. comprises roughly four million infants (approximately 86,000 in Indiana), constant vigilance in vaccinating infants and children on time will ensure that disease levels remain low, and in some cases, approach elimination and possibly eradication.

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# USDA Free Fruit and Vegetable Pilot Program

Judy Rose, RD, CD  
ISDH Chronic Disease Division

## Background

The Nutrition Title of the 2002 Farm Act provided \$6 million for a United States Department of Agriculture (USDA) Free Fruit and Vegetable Pilot Program (FVPP) to be conducted in the 2002-2003 school year. Under the administration of the USDA Food and Nutrition Service (FNS), the "intent of the program is to determine the feasibility of carrying out such a program and its success as determined by the students' interest in participating in the program" according to the legislative language of the bill. Free items, to include fresh or dried fruits and fresh vegetables, were to be made available to students in the pilot schools. Before the pilot was conducted, no one knew if the students would actually eat the fruits and vegetables nor whether the schools could administer such a program.



The conference report from the farm bill recommended Indiana, Iowa, Michigan, and Ohio as the four pilot states along with one Indian Reservation, the Zuni Indian Tribal Organization in New Mexico, with seven participating schools. Each of the four states was allowed to conduct the pilot in 25 schools representing large and small, rural, suburban and urban elementary, middle and high schools. The selection of schools was to include students from diverse ethnic backgrounds and family income levels, as assessed by the proportion of students certified as eligible for free and reduced-price lunches.

The schools were to serve dried or fresh fruit and fresh vegetables (no canned or frozen) at any time during the school day except during regular meal service times. The schools had freedom of choice in the manner of delivery including classroom service, kiosks, free vending machines or a combination of delivery methods. Schools were encouraged, but not required, to conduct educational and/or promotional activities with school events as well as daily classroom schedules. The pilot program was generously funded at approximately \$94 per student.

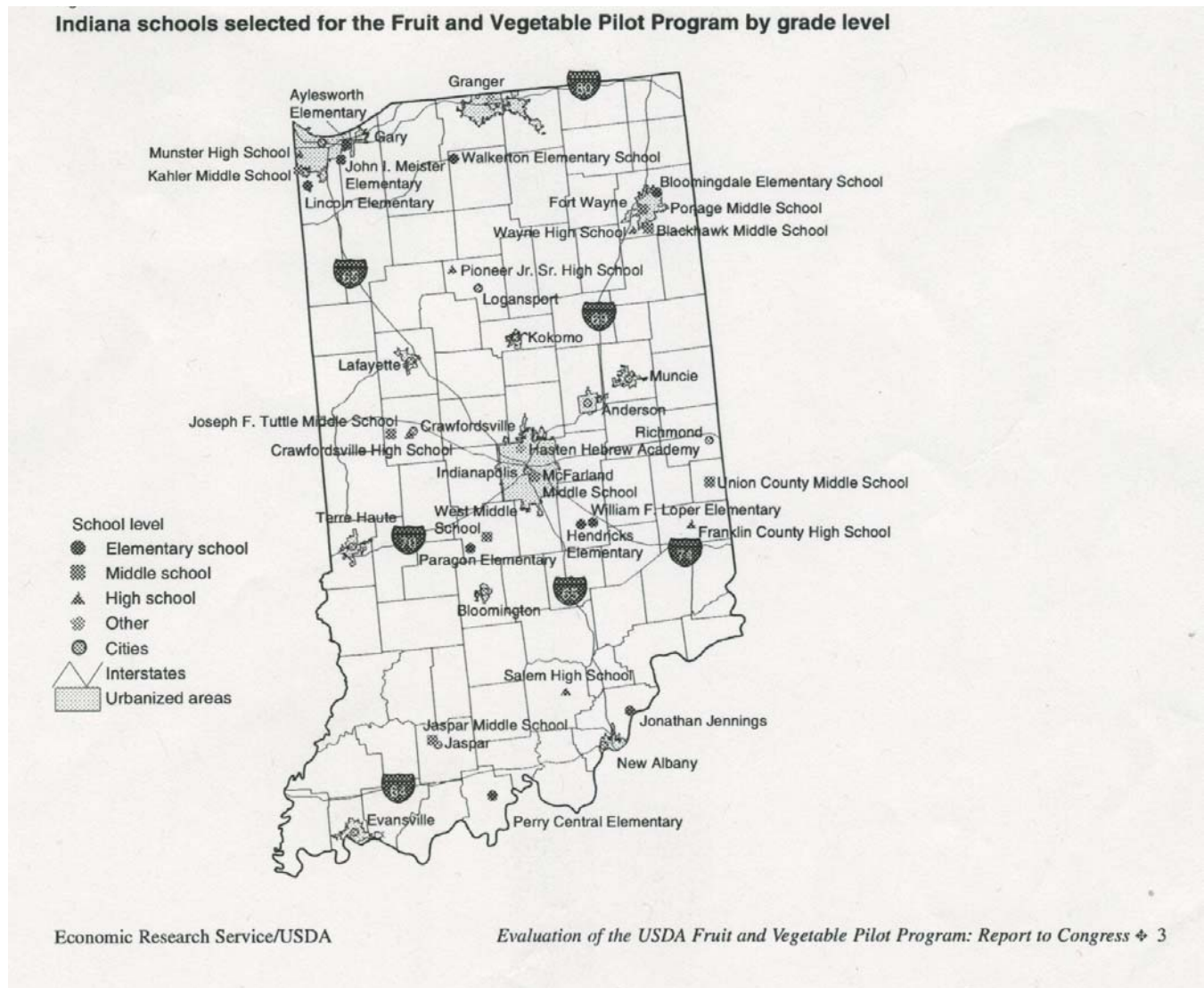
Schools in the four selected states were invited to submit an application to their state school lunch program. The 2002 Farm Bill was enacted in July 2002. The invitation to submit an application came in late July when most of the school food service personnel were on summer leave. Even with that barrier, Indiana still had 106 applications for the 25 pilot slots. The Indiana Department of Education Division of School Food and Nutrition Program reviewed the applications, made comments and sent them to the USDA who made the final selections.

Evaluation of the FVPP was funded as part of the farm bill and assigned to the USDA Economic Research Service (ERS). Congressional deadlines required the evaluation to take place in December 2002, and February 2003. This was a short deadline since most schools were unable to start the pilot program before late October 2002.

## Indiana's Pilot Program

The Indiana schools selected by the USDA Food and Nutrition Service to participate in the FVPP included 1 private and 24 public schools with a total enrollment of 15,059, an average of 553 students per school (Figure 1). There were 10 elementary, 8 middle and 6 high schools with approximately the same total enrollment for each grade. School locations included 9 urban, 8 rural and 8 suburban schools, all of who participate in the National School Lunch Program (NSLP). Ten of the 25 Indiana schools had a high percentage of students who qualify for free and reduced-price school meals, and 15 schools had a low percentage. This was consistent with the distribution of schools in the other 3 states.

**Figure 1.**



All schools selected for the pilot asked to participate and were very enthusiastic. Schools were required to designate a coordinator for the program within the school. Usually, because of the need to receive and store produce, this person was the food service director, but this was not a requirement.

## **The National Pilot Program**

A variety of distribution methods were used by Indiana schools. Most elementary schools found that it was easier to maintain order and include nutrition education by serving the fruits and vegetables in the classroom. The FVPP guidelines allowed schools to serve fresh fruit smoothies and freshly squeezed juice, locally produced, no more than once a week. Only 22 percent of schools served juice. This was probably due to the location of the four states in the pilot program. The only locally produced fresh juice in these states was apple juice. Since the pilot did not start until late in October, there was limited opportunity for this type of fresh juice.

The funding allowed schools to purchase ready-to-serve fruits and vegetables since they were allowed only 10% of the total funds for administrative costs. After paying for additional storage and service items, this amount did not leave enough funds to cover labor costs for preparing the produce in-house. Most schools (96%) bought pre-cut or pre-prepared items (pre-sliced apples, individually bagged carrots, etc.) or served dips, nuts, or small side condiments to complement pilot foods and influence acceptance. Almost 75% of schools made special arrangements to buy prepared trays from local sources. This not only avoided labor costs, but it also allowed for a greater variety and quantity of fresh produce.

Many students were unfamiliar with some fruits and vegetables, but quickly began to accept them. Some incidents were reported of children not knowing how to eat a pear or not realizing that oranges and tangerines had to be peeled before eating. Pilot coordinators seized the opportunity to expose the children to as many new fruit and vegetable items as possible. One new item offered in several Indiana schools was pomegranate seeds, available during the Christmas/New Year's holiday season. Even experienced food service personnel were surprised at how much time was required to extract the colorful, flavorful seeds from the pomegranates and portion them for the children. Schools who made this time investment felt that it was worthwhile after seeing the excitement created among the students.

The FVPP guidelines did not limit the number of times a day the fruits and vegetables were offered nor the time during the day for the offering. Therefore, 79% of schools had multiple distribution times. Most schools (81%) offered the fruits and vegetables during morning school sessions, 63% during afternoon school sessions, 59% after school and 28% before school. Many schools seized this opportunity to provide after-school snacks for students participating in sports or other after-school activities.

Strawberries were reported as the favorite fruit, although hand-held fruit such as apples, bananas, oranges and pears were most commonly served. Dried fruits were not as well accepted as fresh fruits. Carrots, celery and broccoli were the most popular vegetables. Fruits were better accepted than vegetables. Grapes were popular with the school children, but were usually discontinued after becoming a messy problem due to students' using them to throw at each other in food fights rather than eating them. Only a few schools were able to maintain discipline and continue to serve grapes. This was the only item which posed such a problem. Most schools anticipated a problem with trash in the classrooms and halls from the fruits and vegetables. Actually, many school janitors reported less trash from candy wrappers and said that the fruit and vegetable trash was disposed of properly.

## **FVPP Evaluation**

Quantitative data on the effects of the pilot are limited due to the constraints of the study. Some schools reported they had a lower volume of sales of candy and other less nutritious foods, but it was impossible to gather data to support this perception. Another perception was that nearly everyone recognized some health benefit or other value from the pilot including increased attention in class, fewer visits to the school nurse, reduced consumption of less healthy food, and reduced number of unhealthy snacks brought from home. They felt that the pilot increased students' awareness and preference for a variety of fruits and vegetables (particularly less familiar items such as kiwis and fresh pears), helped children who would otherwise be hungry get more food, and increased students' consumption of fruits and vegetables at lunch.

Any evaluation of the FVPP must include the fact that the pilot schools wanted to participate in the program enough to compete for the limited number of slots available. Whether schools without this level of commitment would successfully implement a similar free fruit and vegetable program is unknown. If this program is ever implemented nationwide, commitment of school personnel will be an issue.

This FVPP produced valuable effects, which cannot be measured or put on a scale. It brought school personnel from several departments together working toward a shared goal. The pilot program created a positive relationship between the school food service personnel and the rest of the school staff. This is vital to any successful nutrition program. Students, school personnel and parents were given a reason to examine the nutrition content of foods being offered to school children. It was easy to substitute more healthful items for high fat and sugar items commonly being served for special events and snacks during the pilot project. When funds are depleted, schools are challenged to maintain the health standard when purchasing food items with local funds.

## **Follow-Up**

The FVPP was funded at a high level since no one knew the cost to conduct such a project. Little more than half the available funding was used due to many reasons, including the late start of the program. USDA representatives informed FVPP project coordinators that any unspent funds would revert back to USDA and not be available after June 30, 2003. This did not encourage restraint in purchasing expensive fruits and vegetables, often ready to serve. However, an act of Congress was passed late in the pilot project that will permit pilot schools to continue the program during the 2003-2004 school year until remaining funds are spent. Each state was given the option of redistributing the remaining funds among their pilot schools. All pilot schools were eager to continue the FVPP except one school (not in Indiana) that had personnel changes.

## **Lessons Learned**

Even with the late start in the school year, consensus among students, parents, teachers and other school personnel was that the program was a success. Some of the lessons learned included:

- School children (K-12) will eat fruits and vegetables when given the opportunity.
- Non-food costs will be more than 10% if frugal food purchasing and preparation are implemented.
- More preplanning time is needed for successful, smooth implementation of the program.
- More preplanning time is needed in order to incorporate nutrition education and product promotion.
- Ways are needed to motivate students to eat more vegetables without high fat dips.
- Free fruits and vegetables can be served for less than \$94 per student per year.

## **Recommendations for National Expansion of the FVPP**

Federal legislation has been introduced to extend the FVPP to all states with 25 pilot schools per state. This would be followed by expansion to all schools nationwide. Nationwide expansion of the program at a comparable level of the pilot would cost an estimated \$4.5 billion. This amount could be reduced if less expensive fruits and vegetables were selected and if they were offered only once a day. Participation in the program would need to be voluntary because of the huge amount of work required to make it successful. Pilot schools could help new schools avoid pitfalls and use the program to their best advantage.

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## TRAINING ROOM

### *Epidemiology and Prevention of Vaccine-Preventable Diseases*

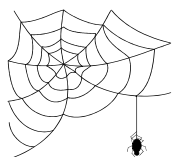
When: September 9-10, 2003

Time: 8:00 am to 5:00 pm

Where: Adam's Mark Hotel, 120 W. Market Street, Downtown Indianapolis

Cost: \$75.00 for 2-day session (breakfast, lunch, & breaks provided)

Registration: Thru [smeechhinh@iupui.edu](mailto:smeechhinh@iupui.edu)



## *Wonderful Wide Web Sites*

### **ISDH Data Reports Available**

**The ISDH Epidemiology Resource Center has the following data reports and the Indiana Epidemiology Newsletter available on the ISDH Web Page:**

[http://www.in.gov/isdh/dataandstats/epidem/epinews\\_index.htm](http://www.in.gov/isdh/dataandstats/epidem/epinews_index.htm)

Indiana Cancer Incidence Report (1990, 95,96, 97)	Indiana Marriage Report (1995, 97, 98, 99, 2000)
Indiana Cancer Mortality Report (1990-94, 1992-96)	Indiana Mortality Report (1999, 2000, 2001)
Indiana Health Behavior Risk Factors (1995-96, 97, 98, 99, 2000, 2001)	Indiana Natality Report (1998, 99, 2000, 2001)
Indiana Hospital Consumer Guide (1996)	Indiana Induced Termination of Pregnancy Report (1998, 99, 2000)
Public, Hospital Discharge Data (1999, 2000, 2001)	Indiana Infectious Diseases Report (2000)
Indiana Maternal & Child Health Outcomes & Performance Measures (1988-97, 1989-98, 1990-99, 1991-2000)	<i>Former</i> Indiana Report of Diseases of Public Health Interest (1996, 97, 98, 99)

## **HIV Disease Summary**

**Information as of July 31, 2003 (based on 2000 population of 6,080,485)**

### ***HIV - without AIDS to date:***

364	New HIV cases from August 2002 thru July 2003	12-month incidence	5.99 cases/100,000
3,736	Total HIV-positive, alive and without AIDS on July 31, 2003	Point prevalence	61.45 cases/100,000

### ***AIDS cases to date:***

451	New AIDS cases from August 2002 thru July 2003	12-month incidence	7.42 cases/100,000
3,446	Total AIDS cases, alive on July 31, 2003	Point prevalence	56.68 cases/100,000
7,226	Total AIDS cases, cumulative (alive and dead)		



## REPORTED CASES of selected notifiable diseases

Disease	Cases Reported in July MMWR Week 27-31		Cumulative Cases Reported January - July MMWR Weeks 1-31	
	2002	2003	2002	2003
Campylobacteriosis	108	92	273	225
Chlamydia	1,355	1,336	9,653	9,585
<i>E. coli</i> O157:H7	15	17	30	42
Hepatitis A	2	12	31	38
Hepatitis B	11	6	19	16
Invasive Drug Resistant <i>S. pneumoniae</i> (DRSP)	17	22	118	109
Gonorrhea	633	552	4,199	3,694
Legionellosis	6	1	9	10
Lyme Disease	4	3	8	7
Measles	0	0	0	0
Meningococcal, invasive	0	4	22	31
Pertussis	14	4	24	32
Rocky Mountain Spotted Fever	1	0	1	0
Salmonellosis	78	78	248	310
Shigellosis	17	13	44	78
Syphilis (Primary and Secondary)	5	7	38	31
Tuberculosis	11	18	66	83
Animal Rabies	6 (all bats)	5	12 (11 bats, 1 skunk)	7 (6 bats, 1 raccoon)

For information on reporting of communicable diseases in Indiana, call the *ISDH Epidemiology Resource Center* at (317) 233-7665.



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